Pharmacy and Therapeutics Committee Meeting
October 10, 2003
Meeting Minutes
Final approved as amended on 2-13-04

Dave Campana facilitating. Meeting was called to order at approximately 8:10 and roll call was taken.

Members present:	**Members present telephonically:**	**Members not present:**
Richard Brodsky, MD	Heidi Brainerd, RPh	Terry Babb, Pharm.D
Charlene Hampton, RPh	Kelly Conright, MD	Michale Boothe, DDS
Arthur Hansen, DDS	Traci Gale, RPh	Robert Carlson, MS
Duane Hopson, MD	Diane Liljegren, MD	John Duddy, MD
Ronald Miller, RPh	Trish White, RPh	Nathaniel Haddock, MD
Richard Reem, MD		Michael Norman, MD
Robert Skala, DO		Mike Orms, MD
Janice Stables, MSN, ANP		Gregory Polston, MD
Alexander vonHafften, MD		George Rhyneer, MD
		Janet Richardson, RPh
		Paul Steer, MD
		George Stransky, MD

Mr Campana addressed housekeeping items and members introduced themselves. Mr. Campana gave a power point presentation on why a PDL is needed. Mr. Bruce Edgren, Pharm D with First Health gave a presentation on how the Alaska P&T committee will work.

The PDL will be mailed to providers. It will also be available on the website and can be downloaded to a PDA. The website version expects to be available after the first of the year. The committee members are to select drugs based on clinical effectiveness and First Health will negotiate for cost effectiveness.

P&T Member questions, discussion and comment:
Q: The goal is to save money but we get no cost information?
A: Cost discussions are not helpful to the process. The committee can determine bottom line on cost and audits can be done if validity is in question. Cost should not be public knowledge.

Q: Would there be a national preferred drug list available?
A: Yes, although it's meant to be a starting point of discussions. First Health has a national P&T Committee and Alaska will provide a member for that committee. The national P&T is meant to be a starting point of discussions of drugs within a therapeutic class. First health will be available for questions and consultation.

C: Initial classes for review will be phased-in, approximately five classes per month. Information will be sent out to committee members on the 1st of November for the meeting

later that month. The first five classes will have soft edits after January and notice will be sent to providers. Provider education is a part of this process.

Specialists can come to the P&T meetings when drugs applicable to their specialty are discussed or they can come to every meeting, it is the member's choice. If the specialist cannot attend the meeting it is asked that they provide presentation material for the committee members to review at the meeting.

Anti-depressants will be discussed with psychiatrists. Psychiatrists will be added to the Committee for discussions of Mental Health drugs.

Q: Can the order of the meetings be changed? DUR in the morning and P&T in the afternoon?
A: After polling members it was decided that the P&T meeting would be held in the morning and the DUR in the afternoon.

Q: Does the 1-800 number work from outside Alaska?
A: The 800 number can be accessed from the lower 48 and from Canada.

Website can be used to remind about meetings, facilitate information dissemination, etc. Will be discussed at the next meeting

Mr. Campana and Mr. Edgren described the PDL process. The committee will examine six drug classes at the next meeting to include ACE inhibitors, ARB's, Beta-blockers, Cox-2 inhibitors, Proton Pump Inhibitors and Statins.

Future committee dates are:
November 21, 2003
December 19 2003
January 16, 2004
February 13, 2004
March 19, 2004
April 16, 2004
May 21, 2004

Mr. Campana opened the meeting to public comments:

Public Questions
Q: Will companies be able to submit evidence statements about particular drugs?
A: Yes, the Committee will accept information, clinical information only. Information may be brought to the meetings or submitted to Sandy Kapur, First Health Services Corporation.

Q: What is the status of the State Plan Amendment and how does that work with First Health, should a company decide to submit a supplemental?
A: The State plan amendment is in process.

Q: Can a company that doesn't participate in the national program participate independently?

A: All companies will need to participate through the multi-state pool.

Q: What percent of the Medicaid budget are pharmaceuticals vs. medical care?
A: About $750 million in medical expenses and pharmacy is about 12.2%.

Q: What happens with a drug that is not on the list and is "pharmacologically more effective?"
A: The Physician needs to document medical necessity. The Pharmacy can then use an indicator on the claim.

Q: How does the PDL increase compliance?
A: The PDL promotes physician compliance in using drugs on the PDL. The PDL does not promote patient compliance in taking medication.

Q: Will the P&T committee, as the deciding body, consider diagnosis separately from PDL issues?
A: Yes, that is possible.

Q: Will the State grandfather some patients and their medications?
A: P&T committee will look at specific classes with exclusions and exceptions being determined by the committee, grandfathering could be an option.

Q: How does this actually save the state money? Using national figures, it seems like Alaska is 10% lower than the national average. Would we lower individual prescription costs or limit the people in the program? It appears that as the number of people goes up, the cost goes up. And actual prescription costs are lower than the national average.
A: The PDL is intended to lower per prescription net cost.
Q: It appears that we are already using the lowest cost drugs and that this may not actually help contain costs for the State of Alaska. The State has already made a commitment to this process without knowing the actual affect on the state budget, and projections from other states are not applicable.
A: Nationally the cost of medical care in Alaska is higher than other states.

Q: What happens if it doesn't work? How long is the contract? Are we stuck with this?
A: We believe that this is a good idea and that it will work. Evidence shows that when given a choice, physicians prescribe the most expensive drugs on the market.

Q: In past experience have you taken the usage of limited drugs and compare it to cost of hospitalization? Using a particular drug may decrease drug costs, but increase hospital/doctor care.
A: Michigan has analyzed this and not found even temporal results. That would be saying that the P&T Committee failed in their duty to provide equivalent drugs.

Q: Will the PDL go out for annual bid for drugs?
A: Yes, however each manufacturer originally bid to provide protection for three years. The manufacturers that originally submitted a bid to the multi-state pool may submit enhanced

bids on an annual basis. Other manufacturers may bid on their drugs when the bid process opens once annually.

Q: You described a lock-in pharmacy. How do you determine which pharmacy a patient goes to fill a prescription?
A: Lock-in patients. – We look at the patient's file and determine which pharmacy the client wishes to use. It must be a single pharmacy.

Q: Do you go to the cheapest pharmacy within the State to save money for the Medicaid system? Mark-ups are not helping to contain costs?
A: No, pharmacies bill usual and customary fee. We pay the lower of U&C or 95% average wholesale cost, plus dispensing fee. We also consider the Federal upper limit.
Q: You could also negotiate with pharmacies for the best price.
A: That's moving toward a sole source contract and leaves out small providers. A sole-source would require a Waiver and that is moving toward managed care.

Q: The contract with First Health – is that a rolling contract? It's difficult to back out of contract where one entity has done all the work. How do you say no to an increase in their fees?
A: The conditions are all in the contract with a set fee.

Q: Why is the contract so closed?
A: Because it has not yet been signed, once signed, it is public information.

Q: Is the $92 million net cost? Will rebates go into the GF? How will you know if we save any money?
A: There is an accounting off-set to the Medicaid budget. The $92 million is net cost of prescriptions – I don't know what we received in rebates through 6-30-03.

Q: Will the contract look at real numbers?
A: Quality assurance will look at real numbers. If it's not producing a savings then we will discontinue. There were $12 million in rebates in '02.
Q: And you're going to save another $6 to 10 million?
A: It's possible.

Meeting adjourned at 10:28

Respectfully submitted

Jeri Powers
Public Health Specialist